EARLY INTERVENTION AND PREVENTION: A WORK IN PROGRESS

A Report Prepared for the

Legislative Finance Committee

By

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INTRODUCTION

In June 2006, the National Conference of State Legislatures (NCSL) in conjunction with three other national organizations[1] hosted a seminar titled "Using Limited Health Dollars Wisely—What States Can Do to Create the Health System They Want" (seminar). The seminar focused on public health and prevention strategies. Teams of legislators, legislative staff, executive branch staff, and other elected officials from seven[2] states were invited to participate. At the seminar, the teams adopted a goal and prepared strategies to implement that goal.[3]

Montana sent a team to the seminar (see Attachment 1). The team adopted a goal to promote a prevention health agenda in the state with an emphasis on interventions that target risk factors in the earliest stages of life – pregnancy through age 3.

Movement toward the goal is an ongoing work in progress. Staff from both the executive and legislative branches have devoted time and effort to develop data, identify programs, list service gaps, and explore options unique to Montana. Since the seminar was held late in the interim between legislative sessions, the project has competed with other demands on staff time and could not be included in the executive planning process (EPP), which would have allowed some policy options to be evaluated for inclusion in the Department of Public Health and Human Services (DPHHS) budget and legislation request for the 2007 session. This report summarizes what has been accomplished since the seminar.

SUMMARY OF SEMINAR

Preventive health strategies, including early intervention, can reduce health, education, judicial system, and corrections costs.[4] New research indicates that 85 percent of the brain's architecture is formed by age 3 to 4. Early intervention focuses on prenatal care and the first 2 to 4 years of a child's life, when services can support important child development and provide the most significant, long term impact. Providing intervention services in the initial years of a child's life can avoid costs in the long term.

While a substantial amount of the savings from early intervention programs occurs over the long run, immediate savings can occur if low-birth weight or premature births are prevented. Early intervention programs have promoted better outcomes for at risk children, increasing their chances of graduating from high school, finding and holding better paying jobs, owning their own home, and avoiding the correction and legal systems.[5] Several studies of various early intervention strategies showed benefit cost ratios in excess of $4 in benefits to $1 in cost over the life of the study. One study showed a $17 to $1 benefit cost ratio over the 60 years that members of the study group were tracked and compared to a control group.[6]

The seminar highlighted research about effective intervention strategies. The Montana team adopted a goal to promote prevention with an emphasis on early intervention and access to prenatal care. Since the June meeting, executive and legislative staff have continued to meet, develop Montana specific data, and identify options for legislative consideration. This report summarizes research and policy options developed since the seminar.

[1] National Governor's Association, Association of Maternal Child Health Programs, and the Association of State and Territorial Health Officials were co-sponsors of the seminar.
[2] State teams from Montana, Alaska, Kansas, New Mexico, North and South Dakota, and Texas attended.
[3] The Montana team is listed in Attachment A.
[4] Rob Grunewald and Art Rolnic, Federal Reserve Bank of Minneapolis, presentation to the seminar "Using Limited Health Dollars Wisely—What States Can Do to Create the Health System They Want", June 22, 2006.
[5] Ibid.
[6] Ibid.

MONTANA DATA

There is an average of 10,902 births per year in Montana. Based on national prevalence data, about 15 percent or 1,635 pregnant women in Montana are at high risk. Risk factors include poverty, homelessness, substance abuse, domestic violence, inadequate nutrition, and access to medical care. These risk factors can contribute to adverse birth outcomes.

Advances in medical technology help people live longer, save many babies that would have died without medical innovations and can help modify or lessen adverse birth outcomes. However, these technologies come at a price. The Legislative Finance Committee (LFC) heard testimony from DPHHS about the cost to the Medicaid program of babies born with medical complications. DPHHS staff noted that neonatal costs and costs to maintain the life of young children born with complicated medical problems were factors that contributed to the projected Medicaid cost over run during FY 2006.

Prematurity and low birth weights are two factors that contribute to higher medical costs at birth compared to normal deliveries. DPHHS staff researched Medicaid cost data over the last 10 years to determine cost comparisons.[7] Figure 1 shows some of the data included in the report and various cost statistics. Although the number of premature births is much smaller than the number of full term deliveries (about 5,500 compared to 41,200 over a 10 year period), there is a much higher percentage of high cost births associated with prematurity. Additionally, the average Medicaid cost over the first year of a newborn's life is about 10 times higher for a premature birth compared to a full term birth - $27,364 versus $2,692.

The study also compared cost for children with uninterrupted Medicaid eligibility for 10 years. For that group, the average cost of a child born prematurely (prior to 37 weeks gestation) is about $55,700. In comparison, the average cost of a full term child is about $20,000, or roughly 2.75 times less.

Figure 1
Selected Medicaid Cost Data
Premature Compared to Full Term Births
FY 1995 to August 2006

Item	Premature	Full Term
Number of Children in Study	5,502	41,200
Average Medicaid Cost Birth to 1 Year	$27,365	$2,692
Number of Children with Medical Costs		
Above $1 Million	5	1
Percent of Group	0.1%	0.0%
Above $100,000	407	196
Percent of Group	7.4%	0.5%

Source:
Ryan Jose, DPHHS, August 2006.

MONTANA PROGRAMS

Public health programs, including those in Montana, provide public education on the importance of prenatal care and offer a variety of services that help improve outcomes for at risk parents and children. Identifying what resources and programs currently exist is a necessary part of understanding what other steps or strategies the Montana team might recommend to accomplish its goal. The next section of this report briefly highlights some of those programs. Attachment 2 includes a table with selected statistics and short summaries of each program examined so far.

The Department of Public Health and Human Services (DPPHS) administers a variety of programs that:

- Educate persons about the importance of prenatal care
- Fund prenatal care and targeted case management for low-income women
- Provide health care for low-income parents and children
- Provide in-home visitation for some at-risk pregnant women and children
- Provide financial assistance to low-income workers for childcare
- Provide food vouchers and coupons to low-income women and children

With the exception of a $0.5 million general fund appropriation for the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) program, all of these programs are entirely or significantly dependent on federal

[7] Ryan Jose, Financial Specialist, Office of Planning, Coordination and Analysis, DPHHS, "Medicaid Costs and Children Born Prematurely", August 2006.

funding. State funds provide the match for Medicaid and most child care programs. Some programs are supported in part by county funds as well.

Prenatal and ongoing health care services are provided to low-income women through the Medicaid program. Medicaid coverage includes a comprehensive set of services, including targeted case management for at risk pregnant women and presumptive eligibility to develop a plan of care and facilitate early access to services. Women must meet financial eligibility. The Montana Initiative for the Abatement of Mortality in Infants (MIAMI) program also provides some prenatal health checks to a limited number of pregnant women at high risk.

Low-income children are eligible for health care through Medicaid and the Children's Health Insurance Program (CHIP) depending on their family income and financial assets. Some early intervention services are funded through Medicaid – primarily for children with a developmental or physical disability.

MIAMI also includes a home visiting component for high risk pregnant women and children. There are 22 entities that contract to provide MIAMI services, which must include a minimum of four home visits for each person served.

Part C of the federal IDEA Early Intervention program provides services for infants and toddlers who have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. Part C services are provided through contracts administered by DPHHS. The schools administer a preschool support grant and part B. The local school district can provide preschool special education in the classroom and related services like physical and speech therapy. The services may be provided at the local school or at other community-based programs. Services are evaluated as the child ages.

Other services available to pregnant women and children include nutrition, childcare, cash assistance, and housing services. DPHHS administers all of these services except housing, which is largely federally funded and managed. Low-income women and children can receive food stamps and may be eligible for the Women, Infants, and Children (WIC) nutrition program. Childcare and cash assistance are available to low-income families who are working or actively looking for work. Federally funded Head Start programs provide education, health, nutrition, and parent involvement services to children from birth to age 5, pregnant women, and their families.

SERVICE GAPS

Legislative staff conducted interviews with program managers and service providers to determine the current Montana service array to support early intervention strategies and asked about perceived strengths and gaps. This part of the report briefly summarizes strengths of the system and the gaps identified in the interviews.

The service system strengths include:

- Prenatal coverage for certain low-income women, including targeted case management services
- Health care coverage for certain low-income children
- MIAMI, a Montana prenatal care and home visiting program
- Nutrition services
- Early childhood services including Head Start and state assistance for childcare
- Other services such as substance abuse, domestic violence programs, housing and legal services

Feedback from service providers and program managers, while acknowledging many of the strengths of early intervention services in Montana, also noted gaps and areas where improvements could be made. Distinct comments are listed in Attachment 3.

Some of the very broad themes identified include:

- Lack of safe, stable housing, making it difficult to locate and deliver services to pregnant women

- Medicaid program limitations, rate inadequacies, and some access problems
- Too few staff for home visiting and the intensity of services needed by some women
- Increasing danger to staff in the home visiting program due to drugs and domestic violence
- Federal changes in citizenship documentation requirements
- TANF work requirements that do not exempt pregnant women

PRELIMINARY OPTIONS LIST

The list of options identified to date concentrate on either expanding or augmenting current Montana programs for at risk pregnant women and young children. The options have been gleaned from interviews with program managers and staff, as well as literature reviews of best practices and evidence based services.

Each option is briefly described. Pertinent information about the option is provided and if there would be a cost to implement the option that is also noted. Preliminary cost estimates have not been developed. Figure 2 shows a summary of the options as well as some selected information including whether the option:

- Has a financial impact
- Can be funded with Medicaid, thereby decreasing the over all cost to the state
- Can be focused using new flexibility granted to states under the federal Deficit Reduction Act[8]

Figure 2
Option List as of October 1, 2006

Option	Added Cost	Medicaid Eligible	Deficit Reduction Act Application: Number Eligible	Deficit Reduction Act Application: Services Provided	Can Tobacco Tax be Used
1 Expand Medicaid Eligibility					
a Pregnant Women and Infants to 1Year	Yes	Yes	Yes	Yes	Yes
b Children up to Age 6	Yes	Yes	Yes	Yes	Yes
c Both a and b	Yes	Yes	Yes	Yes	Yes
2 Increase funding for MIAMI					
a Increase Each Contract Amount	Yes	Partial	?	?	?
b Increase the Number of Sites	Yes	Partial	?	?	?
c Add Service Requirements	Yes	Partial	?	?	?
d Facilitate Medicaid Billing by Providers	Yes				
3 Other Initiatives					
a Increase the Medicaid Rate for Targeted Case Management for Pregnant Women	Yes	Yes	Yes	Yes	Yes
b Reinstate Prevention Program Funding in the Child and Family Services Division	Yes	Unknown		Unknown	Unknown
c Increase Part C Funding to Serve More Children	Yes	No	No	No	No
4 Continue to work on strategies with goal of presenting a plan to the 2009 Legislature					

Option 1: Expand Medicaid eligibility

A recurring theme to enhance prenatal and early childhood outcomes was to expand Medicaid eligibility for pregnant women and eligibility for children. Eligibility expansions can include income and resource changes. Montana Medicaid eligibility for pregnant women and children is established at or near the allowable federal minimum.

[8] States can amend the state Medicaid plan to offer certain Medicaid benefits to a group of persons that would be categorically eligible for Medicaid if the state chose to establish eligibility at that level or for that group. While federal approval of state plan amendments is not fully certain, states can now undertake innovations that used to require a waiver.

As of 2005 Montana, is 1 of 9 states that did not cover a higher income level. Other states eligibility levels ranged from 150 to 275 percent of the federal poverty level, with the most states (19) establishing eligibility at 185 percent of the federal poverty level.[9]

Other suggestions for increasing Medicaid coverage include presumptive and continuous eligibility for pregnant women[10] and removing the asset test for pregnant women.

Option 2: Expand or enrich MIAMI

Home visiting programs have proven cost effective investments for states. Montana has a home visiting program in place with some program elements, such as the minimum number of home visits, determined by evidence based practices. However, the caseloads for MIAMI program staff are high and MIAMI must compete with other public health functions for worker time. Enriching the staffing for MIAMI and adding more or expanding current programs could be considered.

Another component of this option is to facilitate MIAMI contractor Medicaid billing. The Medicaid program is complicated. It can be very time consuming to track allowable services and to bill for services. However, if counties and MIAMI providers could receive assistance, it might enable them to bill Medicaid for allowable services and expand funding for services.

Option 3: Other initiatives

a) Review the rate and allowable activities for Medicaid targeted case management for at risk pregnant women;

Targeted case management services can provide assistance in developing a plan of service for pregnant women who are at risk. The rate ($24 per hour) for providing case management to at risk pregnant women is lowest rate paid among all Medicaid case management rates.[11]

b) Reinstate funding for prevention programs;

Funding for prevention programs for families with children at risk of being placed in foster care has been reduced over the years. MIAMI providers thought that the programs provided valuable incentives for families to participate in services.

c) Increase Part C funding to serve more children

Some interviewees noted that the Part C funding to serve disabled children 0 to 3 was not adequate to serve all children who would qualify.

d) Research and identify strategies to develop or provide affordable, safe housing.

Lack of stable, safe housing has been identified as a significant barrier for at risk pregnant women. This option may be one of the most challenging listed and requires more research to identify programs that exist, how the programs are funded, specific service gaps, and what type of strategies might be effective. Most housing assistance programs are federally or locally funded. If the state has little ability to influence how the programs are managed or funded, any venture into this area might involve implementation of a new program at the state level.

Option 4: Continue to work on strategies with the goal of presenting a plan to the 2009 Legislature

[9] The other states that establish eligibility at 133 percent of the federal poverty level are: Wyoming, Idaho, North and South Dakota, Utah, Nevada, and Arizona. The following number of states establish Medicaid eligibility for pregnant women at various income levels: 9 at 133 percent; 5 at 150 percent; 1 at 175 percent; 19 at 185 percent; 14 at 200 percent; and 2 at 250 percent and above.

[10] All but 9 states, including Montana, provide some length of presumptive and continuous Medicaid eligibility for pregnant women, with the shortest eligibility span being 2 months and the longest being 60 months.

[11] Rate information provided to the Rates Advisory Commission. Case management rates vary from a low of $24 per hour for at risk pregnant women to a high of $18 for adult mental health or $41.84 per visit for a developmentally disabled adult.

This item is listed as an option to continue developing the early intervention initiative next interim. Legislators on the Montana team will consider this issue prior to the next LFC meeting.

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ATTACHMENT 1

Montana State Team Members:

- Senator Greg Lind, MD, Member, Joint Appropriations/Finance and Claims Subcommittee on Health and Human Services; and Member, Finance and Claims Standing Committee
- Senator John Cobb, Member, Member, Joint Appropriations/Finance and Claims Subcommittee on Health and Human Services; Member, Senate Finance and Claims Standing Committee; and Member, Public Health, Welfare and Safety Standing Committee
- Representative William Jones, Member, Human Services Standing Committee
- Representative Teresa Henry, Member, Human Services Standing Committee
- Susan Fox, Director, Legislative Services Division, Montana Legislature
- Lois Steinbeck, Senior Fiscal Analyst, Legislative Fiscal Division, Montana Legislature
- Margaret Bullock, State Health Planning Grant Director, Department of Public Health and Human Services
- Gail Briese-Zimmer, Administrator, Office of Planning, Coordination and Analysis, Department of Public Health and Human Services
- Erin McGowan-Fincham, Health Policy Advisor, Department of Insurance

ATTACHMENT 2

SUMMARY OF MONTANA PRENATAL AND EARLY INTERVENTION PROGRAMS

Matrix of Services in Montana that Support Prenatal Care and Early Intervention for At-Risk Women and Children

Program/Service	Income Limits	Asset Limit	Age Limit	Other Criteria	Total Served in FY 2006	FY 2006 Funding General Fund	FY 2006 Funding Total	Entitlement
Prenatal Care/Targeted Case Management								
Medicaid Funded Health Care								
Women	133%	$3,000						Yes
Health Care								
Medicaid State Plan Health Services								
Women	38%	$3,000						Yes
Children	133%	15,000	0 to 6					Yes
Children	100%	15,000	6 to 18					Yes
Children with a Physical or Developmental Disability	None	None	0 to 18					No
Children's Health Insurance								
Children	150%	n/a	0 to 18					No
Nutrition Services								
Food Stamps					81,665	$0	$90,405,913	Yes
Households - GMI	130%							
No Elderly or Disabled		$2,000						
With Elderly or Disabled		3,000						
Women, Infant, and Children								No
Women	185%	n/a		Pregnant or breast feeding		$0	$11,471,131	
Children		n/a	To Age 6	Women with infants				
Commodities				At nutritional or medical risk				
Case Management Services								
Medicaid								No
Targeted Case Management								
Non Medicaid	n/a	n/a	n/a					
Early Intervention Services								
Part C - IDEA Early Intervention			To Age 3	Children that are diagnosed toward or				Yes
See text block worksheet				experiencing developmental delays				
Schools - IDEA Early Intervention	n/a	n/a	Ages 3-6	Children with disabilities, autism or other	1,925	$0		
See text block worksheet				impairments including traumatic brain injury				
Headstart	100%	n/a		Qualify by income, but up to 10% of the				
Early Headstart - Pregancy to 3			0-3	enrollment can be over income if disabled				
Ages 3 - 5			3 to 5	Totals for both	4,700	$0	$33,846,775	No
Home Visiting								
Montana Initiative for the	n/a	n/a	n/a	Low-income women at risk of substance				No
Abatement of Mortality in Infants				abuse, homlessness, domestic violence				
Follow up for Child			To Age 1					
Fetal Alcohol Syndrome Prevention								
Childcare								
Families Needing Pre-school or	150%	n/a		Must be working or actively looking for	4,312	$5,657,630	$23,859,664	No
After-School Care				employment				
Financial Assistance								
Temporary Assistance for Needy				Must be working, actively looking for				No
Families				for employment, or building job skills				
To Qualify for Cash Assistance	30% of 2002 FPL		n/a					
Benefit Calculation	33% of 2005 FPL			Average monthly cases/ benefits	3,938	$1,202,053	$20,063,009	
Other TANF or MOE Services	150% of 2005 FPL			Other services		$9,797,756	$18,554,987	

PRENATAL CARE

DPHHS has funded ongoing public education about the importance of early and continuing prenatal care for more than two decades. The Medicaid state plan covers prenatal care for low-income women with countable household incomes up to 133 percent of the federal poverty level[12] with resources of $3,000 or less. The table shows the 2006 federal poverty level by family size for various percentages of poverty. Medicaid pays for about 40 percent of the births statewide, slightly higher than the national average of 35 percent.

2006 Federal Poverty Level
Various Incomes by Family Size
and Percent of Poverty Level

Family Size	Percent of 2006 Federal Poverty Level			
	40%	100%	133%	150%
1	$3,920	$9,800	$13,034	$14,700
2	5,280	13,200	17,556	19,800
3	6,640	16,600	22,078	24,900
4	8,000	20,000	26,600	30,000
Each additional person add:				
	1,360	3,400	4,522	5,100

Montana implemented presumptive Medicaid eligibility for pregnant women. Providers who are specially trained initially screen a woman for Medicaid eligibility. If it appears she will meet the eligibility requirements, she is granted presumptive eligibility so that she can access services quickly. Women must complete the eligibility process through the county offices of public assistance to maintain continuous Medicaid eligibility. After completing eligibility through the county office, income eligibility is not screened again until after the birth of the child, but resource levels are checked monthly. If resources rise above $3,000 the woman loses Medicaid eligibility.

Montana has designated at risk pregnant women as a target group to receive Medicaid case management services. A case manager can help a woman develop a plan of service and access needed services.

POST PARTUM CARE

The Medicaid program continues to fund health care for women after they have given birth. Women with incomes below 40 percent of the poverty level have uninterrupted care until their income rises above that level or until they no longer have children in their household. Women with incomes above 40 percent, but lower than 133 percent of the federal poverty level receive another 60 days of care after they give birth.

Infants and children receive health care services through the Medicaid program and the Children's Health Insurance Program (CHIP). Medicaid eligibility for children includes a family asset test (up to $15,000) and income tests by age:

- 133 percent of the federal poverty level until age 6
- 100 percent of the federal poverty level until age 3

Eligibility for Medicaid community based services for developmentally or physically disabled children does not consider family resources or income.

CHIP eligibility does not include an asset test and covers children in families with incomes up to150 percent of the federal poverty level.

Medicaid state plan benefits include more services than the chip plan, which is modeled after the Montana state employee health benefit package. Medicaid benefits are not limited, but CHIP benefits are capped at $1 million per member per lifetime.

NUTRITION PROGRAMS

Low-income pregnant women and children can receive food assistance from two programs – the food stamp and Women, Infants, and Children (WIC) feeding programs. Both are federally funded. The food stamp program is fully federally funded. The food stamp program provides a debit card that can be used to purchase various food

[12] The federal poverty index is updated annually, increasing between 2 to 4 percent most years.

products. When it was originally enacted, the food stamp program was designed to fund 80 percent of a family's monthly food requirements.

WIC provides vouchers to pregnant women and breast feeding women and children up to five years old in households with incomes up to 185 percent of the federal poverty level. If the federal WIC grant is insufficient to fund all eligible applicants, the allowable food items that can be purchased with vouchers are changed. The WIC program is frequently mentioned by service providers as a referral source to their programs.

EARLY INTERVENTION PROGRAMS

There are several early intervention programs in Montana. The federal Part C grant funds services for eligible children from birth through age two who have a diagnosed physical or mental condition[13] that has a high probability of resulting in developmental delay or who are experiencing developmental delays[14].

Eligible infants and toddlers receive an array of services including special instruction, parent and family education and counseling; services for speech pathology and audiology, occupational therapy, physical therapy, and psychological needs; service coordination, social work, home visits, health, vision and nutrition services; assistive technology devices and services; and transportation and related costs.

Schools are required to identify and provide services to children beginning at age 3. Montana's Preschool Special Education Program is administered by the Office of Public Instruction (OPI), Division of Special Education and local school districts, and serves children ages 3 through 5 who meet the definition of "child with a disability." (Includes autism, cognitive delay, deaf-blindness, hearing, orthopedic impairment, health, learning disabilities, speech, and brain trauma injury). Combined meetings set up a process for evaluating the child and determining eligibility for preschool special education services.

Goals and objectives are set to address these identified needs and are based on the child's level of performance. The local school district will have options for meeting the child's educational needs, which can include preschool special education in the classroom and provision of related services like physical and speech therapy which support the specialized instruction. The services may be provided at the local school or at other community-based programs. Services are evaluated as the child ages.

HOME VISITING PROGRAMS

The Montana Initiative for the Abatement of Mortality in Infants (MIAMI) program provides services to at risk pregnant women and infants. The program is funded from the general fund (about half a million a year). Counties and tribes are invited to respond to an RFP that lists specific outcomes that must be accomplished, including prenatal screening, at least four home visits for a pregnant woman or new mother and infant, as well as referral to other services. There are 22 entities that received contracts, with annual amounts ranging from $2,564 to $100,549, with an average cost per client of $197. Contractors must employ a nurse and can employ a social worker and paraprofessional staff, depending on the contract amount.

The MIAMI program has been augmented by a federal grant to prevent fetal alcohol syndrome. Local programs that also received federal grant funds employ additional staff and provide additional substance abuse services.

[13] Such diagnoses can include sensory impairments, inborn errors of metabolism, microcephaly, fetal alcohol syndrome, epilepsy, Down syndrome or other chromosomal abnormalities.

[14] Delays in such areas as cognitive delay; physical development, including vision and hearing; speech and language development; social and emotional development; self-help skills would be considered.

CHILDCARE SERVICES

Low-income working families or low-income persons actively looking for work can receive childcare subsidies. Funding is capped and there can be waiting lists for services in some areas. The state childcare rate pays most of the daily cost in all areas of the state and can cover the entire cost in some areas for some childcare.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

The TANF program provides cash assistance for a limited time and also provides some employment skills development for low-income families. Recent federal changes included in the Deficit Reduction Act of 2005 (DRA) change the types of activities that can count toward work hours.

OTHER SERVICES

There are other services administered by the federal government for at risk pregnant women and low-income families. Housing and legal services are federally managed and identified by service providers as being very important to pregnant women's stability and ability to access services.

ATTACHMENT 3

Service Gaps/Issues

Risk/Additional Comments
Access to prenatal care
Providers not taking presumptive eligibility in some areas of the state
Some women fail to follow through to obtain Medicaid eligibility after presumptive eligibility (must be completed within 30 days)
Citizenship requirements for public assistance
Too young for drivers' licenses
Many clients don't have drivers' licenses
Many don't have access to or can't afford identification cards or birth certificates
Eligibility for services
Asset limits disqualify 2 car households
Pregnant women don't always complete Medicaid eligibility
Hearing impairment
Identification and provision of services earlier could provide significant gains for children
Housing
Shelter housing - 30 day period of eligibility but also had to move every week
Reports of some pregnant women/familes living in storage units and small storage sheds
Charitable organization requires women be married
Pregnant women move from relative to relative or acquaintance to acquaintance
Legal representation
Due process rights when being evicted from housing noted in particular
Medicaid
Rates are too low - transportation and targeted case management mentioned several times
Citizenship proof is hardship
Income and asset eligibility needs to be raised for prenatal/delivery services
Part C
Doesn't serve disability groups equally; centered on developmentally disabled
Prevention programs
Discontinued Partnership to Strengthen Families for families at risk of abuse/neglect
No incentives for families to participate
Public health worker safety
Home visitor present during a Missouri River Drug Task bust
Domestic violence issues prevent home visits
Respite care - lack of respite care
Substance abuse
Meth particularly a problem
TANF
Pregnant women are not exempt from work requirements
Lack of other services for at risk women
Teen parents